Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAN ANTONIO MEDICAL SUPPLIES

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-10-4342-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claims were denied for no preauth. Spoke to Mary in bill review on 5/25/10. Individual billed amounts did not exceed $500.00 Refer to attached TDI rule for preauth necessity. Our claim was reviewed as a total charge amount, which did exceed $500.00. Reconsideration was submitted within timely filing period. MAR amount should be paid for both dates of service."

Amount in Dispute: $489.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor argues that DWC Rule 134.600 controls reimbursement in this case because of section (p)(9). Texas Mutual does not agree, (p)(12) does. Rule 134.600(p)(12) states, '…treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols…' require preauthorization. ODG's treatment guideline for the upper back and neck does not address gel pressure mattresses. Absent preauthorization approval for it, no payment is due. ODG's treatment guideline for the upper back and neck does address the tens/ems four lead unit. ODG does not recommend it. The use of this modality, since it exceeds ODG, would require preauthorization. However, it was not obtained. For this reason no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2009	HCPCS Codes E0730 & E0185	$489.42	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
5. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197-Precertification/authorization /notification absent.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 793-Reduction due to PPO contract. PPO contract was applied by Focus/First Health.
   - 930-Denied in accordance with 134.600(P)(12) as the treatment/service is in excess of the Division's treatment guidelines as outlined in the Disability Management Rules effective 5/1/07. Please refer to the Disability Management Rules, Chapter 137 on the Division's website.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - 891-The insurance company is reducing or denying payment after reconsideration.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Does a preauthorization issue exist?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On November 2, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

   28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

   The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. 28 Texas Administrative Code §134.600(p)(9), states "Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   A review of the requestor's medical billing finds that HCPCS code E0730- Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation; and E0185- Gel or gel-like pressure pad for mattress, standard mattress length and width's charges are less than $500.00.

   The respondent contends that "ODG's treatment guideline for the upper back and neck does not address gel pressure mattresses. Absent preauthorization approval for it, no payment is due. ODG's treatment guideline for the upper back and neck does address the tens/ems four lead unit. ODG does not recommend it. The use of this modality, since it exceeds ODG, would require preauthorization."

   Texas Administrative Code §134.600(p)(12) "Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   28 Texas Administrative Code § 137.100(f) states "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

The requestor billed HCPCS codes E0730 and E0185 for the diagnoses 722.71 and 722.0 found in the neck and upper back.

According to the Neck and Upper Back Chapter of the Official Disability Guidelines (ODG), HCPCS code E0730: "Not recommended as a primary treatment modality, but a one-month home-based TENS trial for neck pain may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Outcomes compared to placebo are not proven in use for whiplash-associated disorders, acute mechanical neck disease, or chronic neck disorders with radicular findings, as evidence is conflicting;" therefore, the disputed HCPCS code E0730, required preauthorization.

Review of the Neck and Upper Back Chapter of the ODG does not list HCPCS code E0185 as a recommended treatment. As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/11/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.